

WEST SUBURBAN HEALTH GROUP

HARVARD PILGRIM PPO CHART July 1, 2014

red font indicates change or clarification	HARVARD PILGRIM HEALTH CARE	
	PPO	
	IN-NETWORK	OUT-OF-NETWORK
BENEFIT	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None
Deductible - (Benchmark Plans only) applies to: In patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - <i>See plan document for full details</i>	None	Individual \$100 Family \$200 per calendar year
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year. NOTE: Prescription co-pays do not count towards the OOP maximum.	\$2,000 per member \$4,000 per family per calendar year - see plan for details	\$1,600 per member \$3,200 per family per calendar year - see plan for details
Family Covered	Spouse; dependents; and adult children until age 26	Spouse; dependents; and adult children until age 26
Selection of Primary Care Physician (PCP)	Any PCP in network	No selection required
Specialist Referrals	Any HPHC Specialist	Any licensed specialist
Providers of Service	HARVARD PILGRIM providers - Members also have access to a wide range of participating providers through the Private Health Care Systems network while outside of MA, NH and ME	Any licensed provider; any hospital
Pre-existing Conditions	No restrictions	No restrictions
INPATIENT		
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Nothing	20% coinsurance after deductible
Physician Services	Nothing	20% coinsurance after deductible
Skilled Nursing Facility	Nothing up to 100 days per calendar year	20% coinsurance after deductible up to 100 days per calendar year
Newborn Well Baby Care (Inpatient)	Nothing	20% coinsurance after deductible
OUTPATIENT		
Emergency Room Visits for Emergency or Accident Care	\$40 copay, waived if admitted	\$40 copay, waived if admitted
Emergency Care in Doctor's Office	n/a	n/a

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Outpatient Surgery in a Day Surgery facility or Hospital	Nothing	20% coinsurance after deductible
CT, MRI and Pet Scans	Nothing	20% coinsurance after deductible
Hemodialysis	Nothing	20% coinsurance after deductible
Physical Therapy	\$5 copay per visit	20% coinsurance after deductible
Office Visits Primary Care Physician	\$5 copay per visit	Not covered
Preventive OV - PCP	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care <i>(Mental Health copays excluded from OOP max)</i>	\$5 copay per visit	20% coinsurance after deductible
Office Visits Specialist	\$5 copay per visit	20% coinsurance after deductible
OB/GYN	\$5 copay per visit	20% coinsurance after deductible
GYN-Preventive Office visit	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	20% coinsurance after deductible
Routine Vision Exam	\$5 copay per visit; one visit per calendar year. \$0 copay for children under 5 yrs of age Eyewear discounts available at participating providers	20% coinsurance after deductible Eyewear discounts available at participating providers
Pre-Admission Testing -	Nothing	20% coinsurance after deductible
Maternity Care visits	Nothing	20% coinsurance after deductible
Dental Services	Children under age 14 - Covered in full for preventative care. All members - \$5 copay for extraction of impacted teeth and initial emergency treatment.	Children under age 14 - 20% coinsurance after deductible for preventative care. All members - 20% coinsurance after deductible for extraction of impacted teeth and initial emergency treatment.
OTHER FEATURES		
Private Duty Nursing <i>(only when medically necessary)</i>	Nothing when medically necessary	20% coinsurance after deductible
Home Health Care	Nothing	20% coinsurance after deductible
Hospice Care	Nothing	20% coinsurance after deductible
Durable Medical Equipment	20% of equipment cost to HPHC not to exceed a member's expense of \$1000,	Deductible, then 20% of equipment cost to HPHC not to exceed a member's expense of \$1000
Ambulance	Nothing, when medically necessary	Nothing, when medically necessary
Radiation Therapy	Nothing	20% coinsurance after deductible
Chemotherapy	Nothing	20% coinsurance after deductible
Chiropractor Visits	\$5 copay per visit, up to \$500 per calendar year	20% coinsurance after deductible

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Prescription Drugs (Inpatient drugs paid in full) Co-pays do not count towards OOP Maximum	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply MedImpact Mail Order: Tier 1: \$10 copay Tier 2: \$20 copay Tier 3: \$75 copay up to a 90 day supply	Retail Pharmacy: Tier 1: \$5 copay Tier 2: \$10 copay Tier 3: \$25 copay up to a 30 day supply No mail order coverage except through MedImpact Mail Order
Fitness Benefit	Reimbursement	Reimbursement
	Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Fitness reimb up to \$150 per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details. Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®

* **Fallon DirectCare** - Members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group, Fallon Clinic, Highland Healthcare Associates IPA, Lahey Clinic, Lawrence General IPA, Lowell General PHO, Mount Auburn Cambridge IPA, and Northeast PHO.

****FCHP SelectCare** - Members have access to FCHP Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern, Massachusetts.